DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REQUEST FOR PUBLIC COMMENT ON VALUE BASED INSURANCE DESIGN

Background

Value Based Insurance Design (VBID) is an innovative solution to maximizing health outcomes with available health care dollars. In most health plans today, cost sharing is used to contain health care spending by exposing patients to out-of-pocket costs for specific services. Health plans generally set uniform cost sharing amounts for specific covered service. However, research shows that higher cost sharing reduces the use of services with high clinical benefit as well as services that provide little clinical benefit for the patient, and may result in worse health outcomes.

In contrast, the VBID approach aligns consumer incentives and payment strategies with value, using both benefits and costs to define value. It does so by reducing barriers, such as cost sharing, to high-value health services and discouraging the use of low-value health services. High-value services are those that have strong evidence of clinical value—typically primary preventive services and treatments for chronic diseases. In contrast, low-value services are those that do not have strong evidence of clinical value, such as services identified by the *Choosing Wisely* campaign. When cost sharing incentives are used in a clinically nuanced manner, VBID improves health care quality and controls spending growth.

The primary objectives of a VBID program are:

- Obtain the greatest positive health impact from medical expenditures.
- Shift the focus of the health care debate away from cost alone to also include the clinical value of health services by restructuring health benefits and payment policies.
- Minimize the lack of adherence to evidence-based services that may result from across-the-board increases in cost sharing levels.

Health Quality and Cost Council

In 2012, the Council began evaluating high-deductible health plans, which require high levels of cost sharing by beneficiaries and have been shown to result in poor quality of care and poor health outcomes. It became a priority of the Council to explore and promote alternative health plan designs that are low cost but also promote high-quality care.

The Evidence Based Medicine Workgroup began pursuing value-based insurance design (VBID) as a new strategy for health plan design in 2012 by bringing in experts across Maryland and the nation to present to the Council on VBID. In 2013, experts from the University of Michigan prepared a white paper reviewing successful VBID programs and proposed a strategy for the Workgroup's consideration. The paper highlighted a set of policy options for promoting VBID in Maryland and a public process to designate services most appropriate for VBID. The Council was presented the initial policy options in September 2013 and felt that the options were worthy of detailed consideration by a larger panel. The Council passed a motion to create the VBID Task Force (Task Force) to designate services and recommend individual policy options for promoting VBID in both health plans in the Maryland Health Benefits Exchange and self-insured plans.

The Council assigned the Task Force six different tasks:

1. Use multiple evidence sources to determine specific clinical areas and services with the greatest potential for improved health outcomes and reduced health care costs.

2. Facilitate a strategic discussion about how the VBID program interacts and complements other elements of state health reform, including payment reform and adoption of health information technology, and incorporate into recommendations.
3. Educate providers, employers, and consumers about the basic tenets of VBID and why the state is embracing the concept.
4. Review and refine policy options developed by consultants and choose most appropriate options based on review of literature and identified list of specific clinical areas and services with greatest potential benefit.
5. Develop and present policy options and specific clinical areas and services to employer groups via Maryland's Healthiest Businesses.
6. Develop and present policy options and specific clinical areas and services to the Maryland Health Benefits Exchange Board.

The Task Force convened throughout 2014 to complete the assigned tasks, but quickly decided to develop a definition that could be applied statewide.

Definition

In order to continue developing and implementing a VBID strategy in the state, the Council is asking the public for comments on a standardized VBID definition for use on the Exchange and self-insured market. This definition will be used to identify and differentiate VBID plans from other insurance products in the state. These comments will assist Council and Task Force with completing the tasks described above. See below for the definition revised during the June 13, 2014 Council meeting.

What is a VBID Plan?

VBID plans are built on the principles of engaging your members in their health and well-being, and designing a benefit plan that 1) promotes wellness by emphasizing primary/preventive care; 2) lowers or removes financial barriers to essential, high-value clinical services; and 3) discourages the use of low-value health services and providers. VBID plans clearly communicate with their members and provide tools to allow members to use their health plan more effectively and efficiently.

VBID benefits are structured to offer rewards and incentives to members for being well and using the health care system efficiently. They align patients' out-of-pocket costs, such as copayments, with the value of services.

A VBID plan would require the following elements:

Incentives

- Incentives to use high-value services for at least three medical conditions. A high-value service is one that provides considerable clinical benefit, relative to the cost;[1]

- At least three health and wellness incentives available to all plan members. Incentives may include disease management programs, health assessments, biometric screenings, tobacco cessation, weight management programs, and other health behavior programs (e.g. Million Hearts); and

[1] Fendrick, A.M., Smith, D.G., and Chernew, M.E. Applying Value-Based Insurance Design to Low-Value Health Services. Health Affairs November 2010 29(11): 2018.

Disincentives

- Disincentives to discourage low-value or unproven services for at least three medical conditions. A low-value or unproven service is one that does not provide substantial health benefit relative to the cost.[2]

All incentives and disincentives must be evidenced-based, supported by professional organizations, and affect a meaningful number of members when implemented.

The mandated preventative benefits covered under the Affordable Care Act will not be considered high-value services.

Request for Public Comment

The Council is requesting public comment on the proposed definition. General comments are welcome and specific questions include:

1. Should the definition be specific about the medical conditions targeted? If so, which conditions?

2. Should the Council consider adopting an alternative approach that relates to the types of incentives and is not linked to particular conditions?

3. How would an incentive that cut across multiple medical conditions best fit into the proposed definition? Examples include tiered prescription drug benefits and site of service differentials.

4. Will Maryland be able to operationalize this definition on the Exchange and self-insured market? If not, why not and how can the definition be revised?

5. What does it mean for an incentives or disincentive to be supported by professional organizations? Is professional support limited to *Choosing Wisely*?

Interested parties may submit comments to Michele Phinney, 201 W. Preston St., Room 512, Baltimore, MD 21201; by fax to (410) 767-6483; or by email to michele.phinney@maryland.gov. Comments must be received by **Friday, September 12, 2014**.

[2] Ibid.